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No. 84-1347

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

SEBASTIAN REBALDO, as CHAIRPERSON OF THE BOARD OF TRUSTEES OF THE UNITED OPTICAL WORKERS INSURANCE FUND,
Petitioner,

vs.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF AMICUS CURIAE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

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INTRODUCTION

The petition for certiorari raises an important issue: whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts "a state statute that prohibits the continuation or negotiation of discount rate agreements between self-insured employee benefit plans and hospitals . . . ." The Second Circuit ruled against federal supremacy, upholding the state statute in an opinion reported at 749 F.2d 133. The Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States"), appearing as *amicus curiae* with the

consent of all parties (*see* Appendix), respectfully requests this Court to grant the petition and reverse the decision below. That decision, if left standing, will erode the federally-protected right of employee welfare plans to self-insure their participants' medical benefits, and will subject those plans to the vagaries of state-by-state regulation that ERISA was designed to preclude.

The state statute at issue is N.Y. Pub. Health Law §2807-a, which deals with hospital charges. Enacted as a cost-containment measure, it directs state officials to "cap," in dollars, each general hospital's annual revenue for in-patient services (§ 2807-a(1)), and directs the hospitals to set their rates so as to generate revenue equal to the "cap" amount (*id.* at -a(6)(a)). The statute establishes two different categories of rates: one for Medicare, Medicaid and state-regulated corporations such as Blue Cross; and a second for other payors including self-insured employee welfare benefit plans. The rates in the second category are 12-15% higher than those in the prime category; to enforce the differential, the statute prohibits hospitals from negotiating discounts with "self-insured and self-administered" employee benefit plans. § 2807-a(6)(b).

The United Optical Workers Insurance Fund, on whose behalf this case was filed, is an employee welfare benefit plan covered by ERISA. For many years the Optical Workers Fund had provided hospital benefits for its members by purchasing Blue Cross insurance. In 1983, beset by rising premiums, the Fund chose to self-insure those benefits. Then, as a direct purchaser of hospital services, the Fund began to negotiate favorable discount rates with individual hospitals, thereby reducing its costs while maintaining benefit levels.

When N.Y. Pub. Health Law § 2807-a outlawed its hospital contracts, the Fund sued to prevent enforcement of the statute on the ground that ERISA had preempted the field. The Fund argued that Congress decided in 1974 that employee benefit plans, many of which operate nationwide, would prosper best under uniform national regulation. Toward that end, ERISA was drafted so as to supersede state laws that "relate to" any welfare benefit plan. The district court ruled in favor of

the Fund, but the Second Circuit reversed. The appellate court held that the language of ERISA did not lead to the "unavoidable conclusion" that Congress had preempted the regulation of hospital rates paid by welfare benefit plans. As a result, the court stated, the federal law allowed New York to outlaw the plans' competitive rate negotiations and to compel self-insured plans to pay substantially higher hospital charges than Blue Cross.

INTEREST OF THE AMICUS CURIAE

Central States, one of the nation's largest employee welfare benefit plans, was established to aid members of the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America. The plan's 150,000 participants are located throughout 34 states.[1]

The Central States welfare plan exists solely to provide medical and other benefits to its participants and their dependents. The plan is funded by employer contributions pursuant to collectively bargained agreements with local affiliates of the International Union. During 1983, Central States used those funds to provide its members with some $350 million in benefits.

At the present time, Central States is almost entirely self-insured: *i.e.*, it pays most medical claims directly out of its own trust funds. Central States has found self-insurance to be cheaper and more efficient than the alternative of purchasing policies from commercial insurers or Blue Cross. Self-insurance has enabled Central States to cope with today's spiraling health care costs by directly negotiating hospital contracts similar to those abrogated by the New York statute. Those arrangements introduce an important element of competition into the health care field while allowing Central States to obtain the best available care for its members at competitive, reasonable prices.

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[1] The pension benefits of Teamsters' retirees are administered by the Central States, Southeast and Southwest Areas Pension Fund, a sister organization of the *amicus curiae*. The pension fund serves 400,000 participants and retirees in all 50 states.

Self-insurance is not a commercially viable option for an employee benefit plan unless the plan retains the right to negotiate the rates it is committed to pay hospitals and other health care providers. Otherwise, self-insurance could result in financial disaster. As a large self-insurer, Central States is directly affected by the rationale of the Second Circuit's decision that the states may regulate the hospital charges paid by employee benefit plans, and burden self-insured plans with significantly higher rates than those paid by Blue Cross.

By permitting New York to set fixed rate-differentials between Blue Cross and self-insured welfare benefit plans, the Second Circuit has turned over to the states the power to drive the self-insured plans out of business. For example, under the rationale of the decision below, ERISA would not supersede a state statute that forced self-insured plans to pay hospital rates 50% higher than those of Blue Cross, requiring the plans to severely reduce benefits, or to pay rates 50% lower, making contracts with the plans economically unattractive to the hospitals. Regardless of how it might be exercised, the power to fix the price at which self-insured plans are compelled to buy health care services is the power to eliminate self-insurance as a benefit plan option. In addition, the combined effect of numerous, and potentially inconsistent, state regulations in this field would spell the end of the federal uniformity envisioned by Congress with the passage of ERISA.[2]

This Court's resolution of the important issue of federal supremacy raised by the decision below will determine whether the states may indirectly control the benefits afforded by self-

[2] New York is not the only state which has chosen to legislate in this field. *See, e.g., Blue Cross & Blue Shield of Alabama v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983). There, an Alabama statute prohibited agreements between third-party payors and pharmacies establishing reimbursement rates that were "less than the usual and customary rates paid by consumers not covered by a third-party plan for the same or similar services." Ala. Code § 34-23-115. The court held that "[a]lthough the Act directly regulates [only] the agreements and relationships between insurers and pharmacies, it effectively regulates what employers and employees can and cannot include in employee benefit plans." The Act therefore "related to" ERISA benefit plans and was preempted. 567 F. Supp. at 1276.

insured welfare plans by fixing the price they must pay for the medical benefits they provide. Because the inescapable effect of the Second Circuit's decision will be to force self-insured plans to reduce benefits or abandon self-insurance, the outcome is of great significance to the millions of American workers whose families rely on employee welfare benefit plans for their health care.

REASONS FOR GRANTING THE WRIT

ERISA, 29 U.S.C. § 1001 *et seq.*, is a comprehensive federal statute designed to protect the interests of the country's employees and their beneficiaries in employer-funded benefit plans. ERISA-protected plans provide either retirement income (pension plans) or medical, disability and other benefits (welfare plans). *See* 29 U.S.C. § 1002(1)-(3). ERISA has codified various uniform standards for these plans, including reporting, disclosure, and fiduciary responsibility regulations. *See* 29 U.S.C. §§ 1021-31, 1101-14.

Congress, by enacting ERISA, "meant to establish [employee benefit] plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Toward that end, Congress inserted an expansive preemption provision into the statute: ERISA § 514(a) provides that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a).

This Court first interpreted § 514(a) in the *Alessi* case, where it invalidated a section of the New Jersey Workers' Compensation Act that prohibited pension plans from reducing, or offsetting, retiree benefits by the amount of workers' compensation awards received after retirement. Noting that Congress had been aware of this offset practice (called integration) when it enacted ERISA (451 U.S. at 521), the Court unani-

mously ruled that the New Jersey statute "relate[d] to" employee benefit plans "because it eliminate[d] one method for calculating pension benefits—integration—that is permitted by federal law." 451 U.S. at 524.[3]

The decision below cannot be squared with *Alessi*. The challenged provisions of New York's Public Health Law equally "relate to" employee benefit plans because they effectively eliminate one method for securing benefits—self-insurance—that is permitted by ERISA. It is indisputable that ERISA covers self-insured plans, and that in 1974 Congress was aware of and approved the concept of benefit plans acting as self-insurers. Indeed, ERISA § 3(a), 29 U.S.C. § 1002(1), defines a welfare benefit plan as a plan or fund established to provide medical or other benefits "through the purchase of insurance *or otherwise.*" (Emphasis added.) Self-insurance is comprehended within the "otherwise" category; when ERISA was enacted, as now, the benefits of employee welfare plans were secured in two main ways: by contracts with commercial insurance carriers, and by the plans' trust assets.

Congress' recognition of this dichotomy is reflected in ERISA's reporting and other requirements as well as in the legislative history. *See, e.g.*, § 103(e), 29 U.S.C. § 1023(e), which requires that specified information be included in a plan's annual report if any benefits are provided through the purchase of insurance, and § 403(b)(1), 29 U.S.C. § 1103(b)(1), which exempts insurance policies from the requirement that all plan assets be held in trust. *See also* H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 257, 296-99, 305 (1974), *reprinted in* Subcommittee on Labor, Senate Committee on Labor and Public Welfare, 3 Legislative History of ERISA 4524, 4563-66, 4572 (1976); 29 C.F.R. § 2560.503-1(c), (f), (g)(2); § 2550.403b-1(a)(1); § 2520.102-3(e); § 2520.104-44. These regulations would be meaningless unless self-insurance is a welfare benefit plan option preserved by ERISA. New York's attempt to regulate the terms on which

[3] In reaching that result, the Court considered it insignificant that New Jersey had intruded upon the federal statutory scheme indirectly, through a workers' compensation law, rather than directly, through a pension regulation enactment. As the Court stated, "ERISA's authors clearly meant to preclude the states from avoiding through form the substance of the pre-emption provision." *Id.* at 525.

self-insured plans may contract with hospitals is therefore "an impermissible intrusion on the federal regulatory scheme." *Alessi*, 451 U.S. at 525.

The Second Circuit, in its attempt to avoid the federal supremacy judgment that logically follows from the *Alessi* analysis, committed a second significant error : it misapplied the ERISA preemption criteria adopted by this Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983). *Shaw* involved two New York statutes which prohibited employee benefit plans from treating pregnancy differently from other disabilities. Even though the challenged state statutes were enactments of general applicability, not aimed solely at employee benefit plans, this Court had "no difficulty" concluding that each was preempted because of its necessary relation to ERISA-covered plans. 103 S.Ct. at 2899.

Focusing on the operative language of § 514(a), the phrase "relate to," the Court observed that a law normally will relate to an employee benefit plan if it has "a connection with or reference to" such a plan. 103 S.Ct. at 2900. Continuing, the Court noted that the language and structure of the preemption provision made clear that Congress had used the words "relate to" in "their broad sense" (*id.* at 2900), and it supported that analysis with a review of ERISA's legislative history. *Id.* at 2900-01.[4] Reaffirming "*Alessi's* recognition of the exclusive federal role in regulating benefit plans" (*id.* at 2900 n.15), the Court held that an affirmation of federal supremacy was mandated by the "plain language" of § 514(a) and the circumstances surrounding its adoption. *Id.* at 2901.

The Second Circuit, after paying lip service to the holding of *Shaw* that § 514(a) must be given "a broad and liberal construction" (749 F.2d at 138), proceeded to do just the opposite, asserting that the New York statute should not be deemed to relate to welfare benefit plans "unless this conclusion is unavoidable." *Id.* at 138. That assertion is flatly contrary to the holding of *Shaw*, which was based on settled principles of statutory interpretation in the federal preemption context.

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[4] Congress' rejection of a more narrowly-drawn preemption provision coupled with statements by ERISA's sponsors "indicated that the section's pre-emptive scope was as broad as its language." 103 S.Ct. at 2901.

"In deciding whether a federal law pre-empts a state statute, [a court's] task is to ascertain Congress' intent in enacting the federal statute at issue." *Shaw*, 103 S.Ct. at 2899; *accord, Brown v. Hotel & Restaurant Employees & Bartenders Int'l Union Local 54*, 104 S.Ct. 3179, 3185 (1984); *Fidelity Federal Savings & Loan Ass'n v. De La Cuesta*, 458 U.S. 141, 152 (1982). The effort to ascertain what Congress wanted the statute to accomplish "is quite simple if, in the federal enactment, Congress has explicitly mandated the pre-emption of state law." *Brown v. Hotel & Restaurant Employees*, 104 S.Ct. at 3185. In that event, the underlying legislative intent is gleaned from the language and structure of the federal statute, with guidance from the legislative history. *See, e.g., Train v. Colorado Public Interest Research Group, Inc.*, 426 U.S. 1, 9-10 (1976); *United States v. American Trucking Associations, Inc.*, 310 U.S. 534, 542-48 (1940). Applying that analysis to ERISA § 514(a), this Court held that Congress intended benefit plan regulation to be "exclusively a federal concern" (*Alessi*, 451 U.S. at 523), and, to achieve that objective, § 514(a) was written to embody the concept of preemption " 'in its broadest sense' " (*Shaw*, 103 S.Ct. at 2901). The decision below cannot be reconciled with those holdings.

The Second Circuit's legal error was compounded by an unrealistic evaluation of the practical effect of the New York law—an evaluation which obscured the dramatic impact of the statute on the structure and economics of self-insured benefit plans. Thus, the court compared a plan's hospital costs to its utility costs, and then moved to a comparison of state labor laws, rent control laws and bridge and highway tolls. 749 F.2d at 138. Those analogies, however, are fatally flawed, for they overlook a critical fact: *the provision of hospital care and other benefits is the sole purpose for the existence of ERISA welfare benefit plans.* As 29 U.S.C. § 1002(1) states, an employee welfare benefit plan must be established "for the purpose of providing . . . medical, surgical, or hospital care or benefits . . . ." The ancillary costs of running a welfare plan's business (*e.g.*, of keeping the office warm in winter) cannot fairly be compared to the plan's cost of fulfilling its central

function of providing hospital and medical care to its participants at reasonable and competitive rates.[5]

Pursuing its "unavoidability" analysis, the Second Circuit opined that there was "no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business." 749 F.2d at 139. That assertion ignores the main thrust of the challenged statute. The New York law fundamentally altered the existing rate structure for the hospital benefits paid by welfare plans, eliminating in the process a system of negotiated discounts that had made it feasible for the plans to self-insure their benefits.[6] By legislating self-insured ERISA plans into a 15% rate disadvantage compared to Blue Cross, New York may well have made it uneconomical for welfare benefit plans to self-insure in that state.

At the same time, however, self-insurance remains the best way to provide hospital coverage in other states. *See, e.g.*, Petition for Certiorari, at pp. 11-13, comparing the challenged New York law with a Massachusetts statute encouraging self-insurance. In this context, the inevitable effect of the New York law will be to force multi-state plans to maintain, side-by-side, at least two different kinds of hospital benefit programs, or to abandon self-insurance altogether. In *Shaw*, this Court held that federal preemption was intended to avoid precisely those results:

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[5] The opinion in *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984), upon which the Second Circuit relied (749 F.2d at 138), does not support the decision below. In *Lane*, an employee of a benefit plan alleged that his discharge had violated state employment discrimination laws. The Ninth Circuit held that those discrimination statutes did not "relate to" the benefit plan because they applied to the plan only "in its capacity as an employer." 743 F.2d at 1340. Here, by contrast, the New York statute strikes at the very heart of the benefit plans' operations—at their role as providers of hospital care and other medical benefits.

[6] *Compare* New York's specific abrogation of discount contracts between hospitals and "self-insured and self-administered groups," N.Y. Pub. Health Law § 2807-a(6)(b), *with* the holding of *Shaw* that a "reference" to benefit plans in a state statute triggers ERISA's preemption provision, 103 S.Ct. at 2900.

> Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state . . . laws . . . would make administration of a uniform nationwide plan more difficult. The employer might choose to offer a number of plans, each tailored to the laws of particular States; the inefficiency of such a system presumably would be paid for by lowering benefit levels . . . ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.

103 S.Ct. at 2904 n.25.

The decision of the Second Circuit, in sum, undermines Congress' intent to "reserve to Federal authority the sole power to regulate the field of employee benefit plans." *Shaw,* 103 S.Ct. at 2901. That decision should be reversed by this Court.

CONCLUSION

The petition of Sebastian Rebaldo for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

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STIPULATION

Pursuant to Rule 36 of the Revised Rules of this Court, the undersigned agree that the Central States, Southeast and Southwest Areas Health and Welfare and Pension Funds may file a brief as *amicus curiae* in support of the petition for certiorari in this case.

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